CHAPTER V BILLING INSTRUCTIONS

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page .
Chapter Subject	Page Revision Date	
Billing Instructions		



CHAPTER V TABLE OF CONTENTS

	Page
Reimbursement Rates	1
Authorization	1
Medicaid Invoices for Case Management Services	1
Submission of Billing Invoices	, 2
Timely Filing of Claims	2
Retroactive Eligibility Rejected or Denied Claims Exceptions	2 3 3
Remittance Voucher (Payment Voucher)	4
Instructions for Completion of the Department of Medical Assistance Services Practitioner Invoice, DMAS-12	5
Exhibit V.1 – Sample DMAS-12	8
Instructions for Completion of the Department of Medical Assistance Services Practitioner Adjustment Invoice, DMAS-220	9
Exhibit V.2 - Sample DMAS-220	11
Patient Information Form - DMAS-122	12
Purpose Disposition of Copies	12 12
Requests for Billing Materials	12
Inquiries Concerning Billing Procedures	13
Exhibit V.3 - Request for Billing Supplies (DMAS-160)	14
Exhibit V.4- Request for Forms/Brochures (DMAS-161)	15

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 1	
Chapter Subject Billing Instructions	Page Revision (Date	



CHAPTER V BILLING INSTRUCTIONS

REIMBURSEMENT RATES

The reimbursement for case management is based on an hourly fee billed to DMAS by the provider agency for only those contacts made directly by the case manager, not by any individuals supervised by the case manager interacting with the AIDS waiver recipient. An hourly rate of \$15 per hour (\$20 per hour in Northern Virginia) up to a maximum amount of 10 hours of case management rendered in any month has been established. This fee must cover all expenses associated with the delivery of, case management services. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative costs that the provider agency incurs. The provider is instructed to total all case management interactions completed during one calendar month and submit a bill to DMAS for the whole number of hours substantiated by the provider's documentation for that month (round to the nearest hour).

AUTHORIZATION

The nursing home pre-admission screening committee shall document the amount of case management service needed on the individual's plan of care. Services in the plan of care are certified as medically necessary by the signatures of the physician and other members of the multidisciplinary screening team and are approved by DMAS prior to implementation. Upon DMAS review and approval of the plan of care, the nursing home pre-admission screening committee shall send a copy of the authorization package to the case manager provider.

MEDICAID INVOICES FOR CASE MANAGEMENT SERVICES

The use of the appropriate billing invoice depends upon the type of billing transaction being completed. Listed below are the two (2) billing forms that are used. Examples of these forms are included in this chapter.

- Practitioner Invoice, DMAS-12
- · Practitioner Adjustment Invoice, DMAS-220

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 2	
Chapter Subject Billing Instructions	Page Revision	Page Revision Date	



Submission of Billing Invoices

Case management providers are instructed to submit claims with a beginning date as that of the first case management service offered in the month and the end date as the date of the last case management service rendered within that calendar month. Invoices must include only allowable charges for the number of hours for services rendered during the calendar month. Any charges submitted prior to the date authorized by DMAS as the begin date will be rejected. Invoices and adjustments must be submitted in the green-edged, self-addressed envelope provided by DMAS. The provider copy must be retained by the provider for record keeping. All invoices must be mailed with proper postage; messenger or hand deliveries will not be accepted. Invoices and adjustments should never be mailed to the Department of Medical Assistance Services address; this will only delay processing. Provider agencies should allow at least three to four weeks for claims processing.

TIMELY FILING OF CLAIMS

Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 15 days from the last date of service or discharge. Federal financial participation is not available for claims which are not submitted within 12 months from the date of the service. Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid may make payment for services rendered more than 12 months before the claim is submitted when the claims are for a recipient who has been determined retroactively eligible for Medicaid. Applicants will be found eligible for Medicaid for up to three months prior to the month of application if the recipient was eligible during this period of time. If the individual received Medicaid-covered services during the retroactive period, Medicaid will accept and process the claim.

When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he has 12 months from the date he is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care or services during this retroactive period are notified by a letter from the local social services department. The practitioner may submit a claim which is more than 12 months from the date of service but is not more than 12 months from the date of the notification of the retroactive eligibility. A copy of the letter from the social services department indicating the date of notification of the retroactive eligibility must be attached to the claim.

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 3
Chapter Subject Billing Instructions	Page Revision Date	



- Rejected or Denied Claims Rejected or denied claims which have been submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:
 - Complete the invoice as explained under the Instructions for Completion of the Department of Medical Assistance Services Invoice, DMAS-12, elsewhere in this chapter.
 - Explain the reason for the late submission in the Remarks section of the invoice and attach written documentation to verify the explanation. This documentation may be photocopies of invoices or denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.
 - Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

Practitioner Department of Medical Assistance Services Post Office Box 27444 Richmond, Virginia 23261-7444

The first copy of a multicopy invoice form should be submitted in the preaddressed Medicaid envelope. The additional copies are retained by the provider for record keeping. All invoices must be mailed (proper postage is the responsibility of the provider and will help prevent mishandling); messenger or hand deliveries will not be accepted.

- Exceptions The state Medicaid agency is required to adjudicate all claims within 12 months of receipt, except in the following circumstances:
 - The claim is a retroactive adjustment paid to a provider who
 is reimbursed under a retrospective payment system.
 - The claim is related to a Medicare claim which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 4	
Chapter Subject Billing Instructions	Page Revision	Date	



- This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.
- The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of these specified criteria.

REMITTANCE VOUCHER (Payment Voucher)

DMAS sends a remittance voucher with each payment. This voucher is a listing of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five years.

The check is the last item in the envelope. The remittance voucher includes an address sheet which has been added for security purposes. The address sheet contains the provider's name and address. The remittance voucher contains a space for special messages from DMAS.

Participating providers are encouraged to monitor the remittance vouchers for special messages that will expedite notification on matters of concern. This mechanism may be used to alert providers on matters that may relate to:

- Pending implementation of policies and procedures
- Sharing clarification on a concern expressed by a provider

Manual Title AIDS Waiver Case Management Services Waiver	Chapter V	Page 5
Chapter Subject Billing Instructions	Page Revision 3-7-92	



INSTRUCTIONS FOR THE USE OF THE HCFA-1500 (12-90) BILLING FORM

To bill for services, the Health Insurance Claim Form, HCFA-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the HCFA-1500. The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information.

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90). Billing Invoice

The purpose of the HCFA-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (A sample of a completed HCFA-1500 claim form follows the instructions for its use.)

Locator		Instructions
1	REQUIRED	Enter an "X" in the MEDICAID box.
1a	REQUIRED	<u>Insured's I.D. Number</u> – Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.
2	REQUIRED	<u>Patient's Name</u> – Enter the name of the recipient receiving the service as it appears on the identification card.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 6
Chapter Subject	Page Revision Date	
Billing Instructions	3-7-92	



Locator	and the same of th	Instructions
9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	REQUIRED	Is Patient's Condition Related To: — Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.) a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)
10d	CONDITIONAL	Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED ;	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	CONDITIONAL	Name of Referring Physician or Other Source
17a	CONDITIONAL	I.D. Number of Referring Physician – Enter the 7—digit Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Reserved for Local Use
20	NOT REQUIRED	Outside Lab?

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 7
Chapter Subject Billing Instructions	Page Revision Date 3-7-92	



Locator		Instructions
21	REQUIRED	Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9 CM diagnosis which describes the nature of the illness or injury for which the service was rendered.
22	CONDITIONAL	<u>Medicaid Resubmission</u> – Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	NOT REQUIRED	Prior Authorization Number
24A	REQUIRED	Dates of Service – Enter the from and thru dates in a 2-digit format for the month, day, and year (e.g., 04/01/92). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.
24B	REQUIRED	<u>Place of Service</u> – Enter the 2-digit HCFA code which describes where the services were rendered. See the Place of Treatment Codes list following the instructions for the appropriate code entry.
24C	REQUIRED	Type of Service - Enter the one-digit HCFA code for the type of service rendered. See the code list following the instructions for the appropriate code entry.
24D	REQUIRED	Procedures, Services or Supplies
		CPT/HCPCS - Enter the 5-character CPT/HCPCS Code which describes the procedure rendered or the service provided. Use code Z9440 for case management services.
		Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable. See the list of modifiers following the instructions for the appropriate entry.
24E	REQUIRED	<u>Diagnosis Code</u> – Enter the entry identifier of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.
24F	REQUIRED	<u>Charges</u> — Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service.

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 8
Chapter Subject	Page Revision	Date
Billing Instructions	3-7-92	;



Locator		Instructions
24G	REQUIRED	Days or Unit – Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service.
24H	CONDITIONAL	<u>EPSDT or Family Plan</u> – Enter the appropriate indicator. Required only for EPSDT or family planning services.
		1 – Early and Periodic, Screening, Diagnosis and Treatment Program Services
		2 – Family Planning Service
24 I	CONDITIONAL.	EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.
24 J	REQUIRED	COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service.
		2 - No Other Carrier
		3 - Billed and Paid
		5 – Billed, No Coverage
24K	REQUIRED	Reserved for Local Use – Enter the dollar amount received from the primary carrier if Block 24J is coded "3". See special instructions if required for your service.
25	NOT REQUIRED	Federal Tax I.D. Number
26	OPTIONAL	<u>Patient's Account Number</u> - Seventeen alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 9
Chapter Subject Billing Instructions	Page Revision [3-7-92	



Locator		Instructions
31	REQUIRED	Signature of Physician or Supplier Including Degrees or Credentials – The provider or agent must sign and date the invoice in this block.
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered
33	REQUIRED	Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your 7-digit Virginia Medicaid provider number in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code.

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page . 10
Chapter Subject Billing Instructions	Page Revision Da	ate



Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22

Medicaid Kesubmission

<u>Code</u> - Enter the 3-digit code identifying the reason for the submission of the adjustment invoice.

Primary Carrier has made additional payment
Primary Carrier has denied payment
Accommodation charge correction
Patient payment amount changed
Correcting service periods
Correcting procedure/service code
Correcting diagnosis code
Correcting charges
Correcting units/visits/studies/procedures
IC reconsideration of allowance, documented
Correcting admitting, referring, prescribing, provider identification number

Original Reference Number – Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each HCFA-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11
Chapter Subject Billing Instructions	Page Revision Da	е



Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22

Medicaid Resubmission

<u>Code</u> – Enter the 3-digit code identifying the reason for the submission of the void invoice.

Original claim has multiple incorrect items 542 Wrong provider identification number 544 Wrong recipient eligibility number 545 Primary carrier has paid DMAS maximum allowance 546 Duplicate payment was made 547 Primary carrier has paid full charge 548 Recipient not my patient 551 Void is for miscellaneous reasons 552 Other insurance is available 560

Original Reference Number – Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each HCFA-1500 submitted as a <u>Void Invoice</u>. (Each line under Locator 24 is one claim.)

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11.1
Chapter Subject Billing Instructions	Page Revision Date 3–7–92	



PLACE OF SERVICE CODES

HCFA-1500 CODE

00.10	Unassigned
00-10	Office location
11 12	Patient's home
12 13–20	Unassigned
	Inpatient hospital
21	Outpatient hospital
22 23	Emergency room
23 24	Ambulatory surgical center
24 25	Birthing center
26 26	Military treatment center
27-30	Unassigned
31	Skilled nursing facility
32	Nursing facility
	Custodial care facility
33 34	Hospice
-	Unassigned
35-40 41	Ambulance – land
42	Ambulance – air or water
42 43–50	Unassigned
51	Innatient asychiatric facility
52	Psychiatric facility - partial hospitalization
52 53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment
30	facility
56	Psychiatric residential treatment center
57–60	Unassigned
61	Comprehensive inpatient rehabilitation
01	facility
62	Comprehensive outpatient rehabilitation
02	facility
63-64	Unassigned
65	End stage renal disease treatment facility
66-70	Unassigned
71	State or local public health clinic
72	Rural health clinic
73-80	Unassigned
81	Independent laboratory
82-98	Unassigned
99	Other unlisted facility

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11.2	
Chapter Subject Billing Instructions	Page Revision Date 3-7-92		



TYPE OF SERVICE CODES

CODE	DESCRIPTION
1	Medical care
2	Surgery
3	Consultation
4	Diagnostic x-ray
5	Diagnostic laboratory
6	Radiation therapy
7	Anesthesia
8	Assistance at surgery
9	Other medical care
0	Blood or packed red cells
Α	Used DME
F	Ambulatory surgical center
Н	Hospice
L	Renal supplies in the home
M	Alternate payment for maintenance dialysis
N	Kidney donor
V	Pneumococcal vaccine
Y	Second opinion on elective surgery
Z	Third opinion on elective surgery

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11.3
Chapter Subject Billing Instructions	Page Revision Date 3-7-92	



PROCEDURE MODIFIERS

HCPCS/CPT

TC	Technical c	omponent
22	Unusual ser	vice
26	Professiona	d component
50	Bilateral pr	rocedure
51	Multiple pr	ocedures
52	Reduced se	ervices
75	Concurrent	care
80	Assistant s	urgeon
81	Minimum a	assistant surgeon
82	Assistant s	argeon

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11.4
Chapter Subject Billing Instructions	Page Revision D	Date



PROCEDURE MODIFIERS FOR EPSDT

MODIFIER CODE

Н	No abnormalities found, no treatment required, and no referral required
K	Abnormality found, treatment has been initiated by myself, and no other referral required
Т	* Abnormality found, treatment has been initiated by myself, and referral to another practitioner has been made
U	* Abnormality found, no treatment has been initiated by myself, and referral to another practitioner has been made
W	Abnormality found, no treatment has been made at this time, referral to myself for treatment within the next 120 days
Y	Abnormality found, treatment/referral has been refused by the recipient or the responsible adult in the case
Z	Abnormality found, no treatment has been initiated, no referral has been made. The recipient is already under care.

^{*} When abnormality referrals are made by a physician to other practitioners, the names of the practitioners and the appointment dates must be provided on an attachment and the word "ATTACHMENT" entered in Locator 10d.

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11.5
Chapter Subject Billing Instructions	Page Revision Date 3-7-92	9



SAMPLE

COMPLETED HEALTH INSURANCE CLAIM FORM (HCFA-1500)

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Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11.6
Chapter Subject Billing Instructions	Page Revision Da 3-7-92	te



SAMPLE

COMPLETED HEALTH INSURANCE CLAIM FORM (HCFA-1500) AS AN ADJUSTMENT INVOICE

PLEASE DO NOT STAPLE IN THIS AREA					A	PPROVE	D OMB-0938-0008
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1 MEDICARE MEDICAID CHAMPUS CHA [Medicare #) X (Medicard #) (Sponsor & SSN) (V.	MPVA GROUP HEALTH PLAN 1 File #1 / ISSN 01101		A 14 INSURED S I D	NUMBER	*****		PROGRAM IN ITEM
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LEE, MAY	3. PATIENT'S BIRTH DATE		4. INSURED S NAM	E (Las: Nam	e, First Nav	e. Middle	innal)
PATIENT'S ADDRESS (No.: Street)	6. PATIENT RELATIONSHI	M F					
	Set Soouse C		7 INSURED S ADD	AESS (No., S	Street)		
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Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11.7
Chapter Subject Billing Instructions	Page Revision Date	



SAMPLE

COMPLETED HEALTH INSURANCE CLAIM FORM (HCFA-1500) AS A VOID INVOICE

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Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11.8
Chapter Subject Billing Instructions	Page Revision Da	te



SPECIAL BILLING INSTRUCTIONS

CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care physician bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. Covered outpatient services excluded from this requirement include: renal dialysis clinic services, routine vision care services, BabyCare services, personal care services (respite care or adult day health care), ventilator-dependent services, EPSDT, and prosthetic services.

All services should be coordinated with the primary health care provider whose name appears on the recipient's eligibility card. Other DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

A physician treating a restricted recipient as a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number (as indicated on the recipient identification card) in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted recipient is treated on referral from the primary physician, enter the primary care physician's Medicaid provider number (as indicated on the card) and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted recipient is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 11.9
Chapter Subject Billing Instructions	Page Revision I	Date



SPECIAL BILLING INSTRUCTIONS

MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, HCFA-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid Physician Manual.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client <u>must place the Medicaid Provider Identification Number of the PCP in Locator 17a</u> of the HCFA-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 12	
Chapter Subject Billing Instructions	Page Revision	Date	



PATIENT INFORMATION FORM (DMAS-122)

Purpose

This form is used by a local Department of Social Services and Medicaid providers to exchange information on:

- The responsibility of an eligible client to make payment toward the cost of care
- The admission, discharge, or death of the client
- Other information known to the provider that might involve a change in the eligibility or patient pay responsibility

The form shall be prepared by the provider to request a Medicaid number, eligibility determination, or confirmation of the patient pay or to notify the local Department of Social Services of changes in the client's circumstances. A new form is to be prepared by the local Department of Social Services at the time of each redetermination of eligibility and whenever there is any change in the client's circumstances that results in a change in the amount of patient pay. (See Appendix B for a copy of the form and the instructions for its completion.)

Disposition of Copies

The case manager will initiate the form to notify the local Department of Social Services that the individual has been admitted to the program and to provide the beginning date of service. Upon the determination of eligibility, the DMAS-122 will be returned to the case manager with the following information:

- The client's financial responsibility toward the cost of care (even if there is none)
- The amount and sources of finances

There must be a completed DMAS-122 form in the client's file prior to billing DMAS.

REQUESTS FOR BILLING MATERIALS

The Provider Enrollment/Certification Unit of the Department of Medical Assistance Services is responsible for the distribution of all forms pertaining to home and community-based care services.

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page 13	
Chapter Subject	Page Revision	Page Revision Date	
Billing Instructions			



The DMAS Request for Forms/Brochures form (DMAS-161) or Request for Billing Supplies form (DMAS-160), as appropriate, must be used by providers to order the DMAS-12, DMAS-220, or DMAS-122 forms. (Examples of these ordering forms are included as Exhibits V.3 and V.4.) A six-month supply of forms should be ordered at least three weeks prior to the anticipated need.

Submit the Request for Forms/Brochures or Request for Billing Supplies to:

DMAS Order Desk North American Marketing 3703 Caroline Avenue Richmond, Virginia 23222

Any requests for information or questions concerning the ordering of forms should also be directed to the address above, or call 329-4400 in the Richmond area or 1-804-329-4400 from all other areas.

INQUIRIES CONCERNING BILLING PROCEDURES

Inquiries concerning covered benefits, specific billing procedures, or remittances should be directed to the Medicaid HELPLINE number:

786-6273 R 1-800-552-8627 A

Richmond Area All Other Areas

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on State holidays.

Manual Title AIDS Waiver Case Management Services Manual	Chapter V	Page
Chapter Subject	Page Revision Date	
Billing Instructions		



EXHIBIT V.3

REQUEST FOR BILLING SUPPLIES (DMAS-160)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES REQUEST FOR INVOICES/ENVELOPES

Name		Da	ite
Provider Number		Contact Person	
		Telephone # ()
		(Area	
Check As Ap	propriate		
P14	ase forward <u>preprinted</u> invoices	as indicated below	
P1	ease forward invoices suitable f eer (See Order Below)		
Quantity:	Dental:	Quantity:	Pharmacy:
	Form 701 Invoice		Form 173 Drug Claim Ledger
	Form 702 Invoice Adjustment		Form 228 Drug Claim Adjustment
	Form 704 Preauthorization Req		Form 664 Envelope
	Form 703 Envelope		
	Home Health Agency		Practitioner:
	Form 92 Invoice		Form 12 Invoice
	Form 219 Invoice Adjustment		Form 220 Invoice Adjustment
***************************************	Form 662 Envelope		Form 663 Envelope
			Screening (EPSDT):
	Hospital:		Form 25 Invoice
	Form 660 Envelope		Form 26 Invoice Adjustment
	٠		Form 660 Envelope
	Laboratory		Special Service: NOT PREPRINTED
	Form 123 Invoice		Form 199 Invoice
	Form 230 Invoice Adjustment		Form 233 Invoice Adjustment
	Form 665 Envelope		Form 666 Envelope
	Nursing Home:		Title XVIII: NOT PREPRINTED
	Form 215 Invoice		Form 30 (Medicare) Deductible
	Form 262 Invoice Adjustment		and Coinsurance Invoice
	Form 661 Envelope		Form 31 Invoice Adjustment
	Personal Care: NOT PREPRINTED		Iransportation: NOT PREPRINTED
	Form 93 Invoice		Form 7 Invoice
	Form 94 Invoice Adjustment		Form 8 Invoice Adjustment
·	Form 659 Envelope		Form 666 Envelope

Please return this form to: Provider Enrollment/Certification Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300

Richmond, VA 23219

Manual Title AIDS Waiver	Chapter	Page
Case Management Services Manual	v	15
Chapter Subject	Page Revision Date	
Billing Instructions		



EXHIBIT V.4

REQUEST FOR FORMS/BROCHURES (DMAS-161)

Department of Medical Assistance Services Request for Forms/Brochures

Provider Number		Contact Person
		Telephone # ()
		(Area Code)
Quantity	Form Number	Form Name
	DMAS-13	Medicaid Driver Registration Form
	DMAS-15	Second Opinion for Surgery Form
	DMAS-16	Maternity Risk Screen
	DMAS-17	Infant Risk Screen
	DMAS-20	Consent Form for Release of Information Rev 1/90
	DMAS-50	Maternal Care Coordinator Record
	DMAS-51	Infant Care Coordinator Record
		Care Coordination Service Plan
		Pregnancy Outcome Report
	DMAS-54	Infant Outcome Report
	DMAS-55	Care Coordination Letter of Agreement
		Practitioner Referral Form
	DMAS-77	ICF/MR Utilization Review Assessment
	DMAS-774	Programs (Objective Continue Continue)
	DMAS-89	Programs/Objective Continuation Sheet
	DMA S_90	Personal Care Recipient Admissions Envelope
	OMAS-70 DMAS-77 DMAS-77 DMAS-90 DMAS-95 DMAS-95 OMAS-95 OMAS-97 DMAS-97 DMAS-97 DMAS-999 DMAS-999 DMAS-999 DMAS-999	Personal Care Aide Record
	DHAS-95MI/MR	Assessment Process
	00-35-111711R	Supplemental Assessment Process Form
	DMAS 07	Nursing Home Pre-Admission Screening Plan Plan of Care for Personal Care Services
	DMAS-974	Plan of Care for Personal Care Services
	DMAS OR	
	DHAS 00	Documentation of R.N. Supervisory Visit
	DMAS 100	Recipient Progress Report
	DMAS 110	Transportation Preauthorization Form
	DMAS 121	Social History Form
	DMAS-108 DMAS-119 DMAS-121 DMAS-121-A	Certificate of Patient Status
	DMAC 122	Certificate of Patient Rehabilitative Services
	DMAS-122 DMAS-200	ratient information
	DMAS 201	Appeal to Medical Assistance Appeals Board
	DMAS-201 DMAS-212	Notification of Medicald Transportation Denial
	DMAS-212	IIVE ALA ENFOLIMENT
	DMAS-300	Respite Care Needs Assessment and Plan of Care
	DMAS-301	
	DMAS=302 DMAS=351	Addit day nearth tare pails lon
	DMA5-351	reduest tor than Services
	DMAS-353 DMAS-403	EPSDT Documentation Form
	UMAS-403	Title XIX Admission Certification Psychiatric Hospital
	DMAS-408	
	1/MAN=417	Heurtain Request for Psychiatric Extension Treatment
	DHAS-420	REGUES: 10f MOSDICE Manatite
	DMAS=420 DMAS=421	Hospice Benefits Revocation/Change Statement
	Dr W3-440	REQUEST for Authorization of DMC and C
	DMAS-450	REQUEST FOR AUTHORISATION of Extended Home Harlist C
	DMAS-999	inite raity Liability Intormation Penart
	DMAS-1000	INITO PARTY LIABILITY Information Report
	DMAS-3004	Stern lization Consent Form
	DMA 5-3005	Acknowledgement of Receipt of Hysterectomy Information
	DMAS-3006	MUNICION CERCITICACION
	DMA S-4000	Prosthetic Device Preauthorization Form
antity	Form Number	Brochure Name
	DMA 5-1	Medicaid Health Charles
	DMAS-2	Medicaid Health Checkup Program
	DMAS=4	Virginia Medicaid Handbook "Spend-Down" Sheet
	DMAS-60	Raby(are (feelist)
	DMA\$-61	BabyCare (English) BabyCare (Spanish)
***************************************		BabyCare (Spanish)
	DMAS-62	BabyCare (Vietnamese)
	DMAS-63	BabyCare (Laotian)
	DMAS-64	BabyCare (Cambodian)
	DMA\$-66	Emergency (are
	DMAS-67	Planning Ahead: A Guide for Virginians with Disabilities
		with Disabilities

Please return this form to: Provider Enrollment/Certification Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219